FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032169

Facility Name: SHABBONA HEALTHCARE CENTER

Address: W. COMMANCHE STREET (Number) SHABBONA (City) 60550 (Zip Code)

County: DEKALB

Telephone Number: (815) 824-2194 **Fax #** (815) 824-2188

IDPA ID Number: 363503389001

Date of Initial License for Current Owners: 04/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	91	Skilled (SNF)	91	33,215	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	91	TOTALS	91	33,215	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,010	3,149	1,383	5,542	8
9	SNF/PED					9
10	ICF	9,684	9,055		18,739	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,694	12,204	1,383	24,281	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.10%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 10 and days of care provided 1,383

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	145,457	7,453	6,720	159,630		159,630	(162)	159,468			1
2	Food Purchase		112,051		112,051		112,051	(563)	111,488			2
3	Housekeeping	181,573	69,363		250,936		250,936		250,936			3
4	Laundry	71,427	11,014		82,441		82,441		82,441			4
5	Heat and Other Utilities			77,702	77,702		77,702	1,056	78,758			5
6	Maintenance	62,284	26,882	7,304	96,470		96,470	(73)	96,397			6
7	Other (specify):*											7
8	**TOTAL General Services**	460,741	226,763	91,726	779,230		779,230	258	779,488			8
	B. Health Care and Programs											
9	Medical Director			4,761	4,761		4,761		4,761			9
10	Nursing and Medical Records	1,027,289	11,139	58,037	1,096,465		1,096,465	(126)	1,096,339			10
10a	Therapy			150	150		150		150			10a
11	Activities	76,274	6,106		82,380		82,380		82,380			11
12	Social Services	84,251		8,383	92,634		92,634		92,634			12
13	Nurse Aide Training			1,910	1,910		1,910		1,910			13
14	Program Transportation			1,458	1,458		1,458		1,458			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,187,814	17,245	74,699	1,279,758		1,279,758	(126)	1,279,632			16
	C. General Administration											
17	Administrative	58,089		60,000	118,089		118,089	24,888	142,977			17
18	Directors Fees											18
19	Professional Services			91,017	91,017		91,017	(56,098)	34,919			19
20	Dues, Fees, Subscriptions & Promotions			49,289	49,289		49,289	(21,405)	27,884			20
21	Clerical & General Office Expenses	138,869	2,350	46,085	187,304		187,304	28,541	215,845			21
22	Employee Benefits & Payroll Taxes			288,820	288,820		288,820		288,820			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,240	1,240		1,240	4	1,244			24
25	Other Admin. Staff Transportation			7,612	7,612		7,612	252	7,864			25
26	Insurance-Prop.Liab.Malpractice			43,967	43,967		43,967	694	44,661			26
27	Other (specify):*							8,760	8,760			27
28	**TOTAL General Administration**	196,958	2,350	588,030	787,338		787,338	(14,364)	772,974			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,845,513	246,358	754,455	2,846,326		2,846,326	(14,232)	2,832,094			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER #0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			32,327	32,327		32,327	74,879	107,206			30
31	Amortization of Pre-Op. & Org.							2,921	2,921			31
32	Interest			82,145	82,145		82,145	87,080	169,225			32
33	Real Estate Taxes			45,785	45,785		45,785	2,326	48,111			33
34	Rent-Facility & Grounds			298,935	298,935		298,935	(298,935)				34
35	Rent-Equipment & Vehicles			653	653		653	686	1,339			35
36	Other (specify):*											36
37	TOTAL Ownership			459,845	459,845		459,845	(131,043)	328,802			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		24,331	106,657	130,988		130,988		130,988			39
40	Barber and Beauty Shops			3,900	3,900		3,900	(3,900)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,823	49,823		49,823		49,823			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		24,331	160,380	184,711		184,711	(3,900)	180,811			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,845,513	270,689	1,374,680	3,490,882		3,490,882	(149,175)	3,341,707			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,941	30		9
10	Interest and Other Investment Income	(1,113)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(563)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(248)	21		18
19	Entertainment				19
20	Contributions	(1,206)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,813)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(9,130)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,132)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(124,044)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (124,044)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (149,175)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS
SHABBONA HEALTHCARE CENTER

ID# 0032169
Report Period Beginning: 01/01/02
Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	ILC-LTC - COPE	$ (1,425)	20	1
2	THEFT AND DAMAGE LOSS	(612)	21	2
3	TRUST FEES	(150)	21	3
4	BARBER & BEAUTY INCOME	(3,900)	40	4
5	CAPITALIZE R&M	(1,078)	06	5
6	BLDG. REPLACEMENT TAX	(248)	21	6
7	BLDG. ACCOUNTING FEES	(549)	19	7
8	LEGAL - PY	(1,168)	19	8
9				9
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94				94
95				95
96				96
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98				98
99				99
100				100
101	Total	(9,130)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(162)							(162)	1
2	Food Purchase	(563)											(563)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,056									1,056	5
6	Maintenance	(1,078)		1,005									(73)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(1,641)		2,061		(162)							258	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records					(126)							(126)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**					(126)							(126)	16
	C. General Administration													
17	Administrative			24,888									24,888	17
18	Directors Fees													18
19	Professional Services	(1,717)	549	(60,901)	5,971								(56,098)	19
20	Fees, Subscriptions & Promotions	(21,444)		39									(21,405)	20
21	Clerical & General Office Expenses	(1,258)	248	29,551									28,541	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			4									4	24
25	Other Admin. Staff Transportation			252									252	25
26	Insurance-Prop.Liab.Malpractice			694									694	26
27	Other (specify):*			8,760									8,760	27
28	**TOTAL General Administration**	(24,419)	797	3,287	5,971								(14,364)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(26,060)	797	5,348	5,971	(288)							(14,232)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	5,941	67,784	1,154									74,879	30
31	Amortization of Pre-Op. & Org.		2,921										2,921	31
32	Interest	(1,113)	181,077	889	(93,773)								87,080	32
33	Real Estate Taxes			2,326									2,326	33
34	Rent-Facility & Grounds		(298,935)										(298,935)	34
35	Rent-Equipment & Vehicles			686									686	35
36	Other (specify):*													36
37	TOTAL Ownership	4,828	(47,154)	5,055	(93,773)								(131,043)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(3,900)											(3,900)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(3,900)											(3,900)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(25,132)	(46,357)	10,403	(87,802)	(288)							(149,175)	45

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SHELDON WOLFE	50%	SEE ATTACHED		SEE ATTACHED		
ALBERT MILSTEIN	50%	SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 298,935	SHABBONA BUILDING LLC	100.00%	$	$ (298,935)	1
2	V	32	INTEREST EXPENSE		SHABBONA BUILDING LLC	100.00%	229,407	229,407	2
3	V	30	DEPRECIATION EXPENSE		SHABBONA BUILDING LLC	100.00%	67,784	67,784	3
4	V	19	ACCOUNTING FEES		SHABBONA BUILDING LLC	100.00%	549	549	4
5	V	31	AMORTIZATION		SHABBONA BUILDING LLC	100.00%	2,921	2,921	5
6	V	32	INTEREST INCOME	48,029	SHABBONA BUILDING LLC	100.00%		(48,029)	6
7	V	21	REPLACEMENT TAX		SHABBONA BUILDING LLC	100.00%	248	248	7
8	V	32	GAIN/LOSS IN PARTNERSHIP	301	SHABBONA BUILDING LLC	100.00%		(301)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 347,265			$ 300,909	$ * (46,357)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.W. MANAGEMENT	100.00%	$ 1,056	$ 1,056	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT	100.00%	1,005	1,005	16
17	V	17	CHIEF FINANCIAL OFFICER		S.W. MANAGEMENT	100.00%	9,867	9,867	17
18	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT	100.00%	299	299	18
19	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT	100.00%	39	39	19
20	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT	100.00%	29,551	29,551	20
21	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT	100.00%	4	4	21
22	V	25	TRANSPORTATION		S.W. MANAGEMENT	100.00%	252	252	22
23	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT	100.00%	694	694	23
24	V	27	PAYROLL TAXES		S.W. MANAGEMENT	100.00%	5,803	5,803	24
25	V	30	DEPRECIATION		S.W. MANAGEMENT	100.00%	1,154	1,154	25
26	V	32	INTEREST EXPENSE		S.W. MANAGEMENT	100.00%	889	889	26
27	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT	100.00%	2,326	2,326	27
28	V	35	AUTO LEASE		S.W. MANAGEMENT	100.00%	686	686	28
29	V								29
30	V	17	SALARY - SHELDON WOLFE		S.W. MANAGEMENT	100.00%	75,021	75,021	30
31	V	17	SALARY - RONNIE KLEIN						31
32	V	27	EMP. BEN.-SHELDON WOLFE		S,W. MANAGEMENT	100.00%	2,957	2,957	32
33	V	27	EMP. BEN.-RONNIE KLEIN						33
34	V								34
35	V	17	MANAGEMENT FEES	60,000	S.W. MANAGEMENT	100.00%		(60,000)	35
36	V	19	HOME OFFICE FEES	61,200	S.W. MANAGEMENT	100.00%		(61,200)	36
37	V								37
38	V								38
39	Total			$ 121,200			$ 131,603	$ * 10,403	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	SFO ASSOCIATES	100.00%	$ 5,971	$ 5,971	15
16	V	32	INTEREST		SFO ASSOCIATES	100.00%	135,358	135,358	16
17	V								17
18	V								18
19	V								19
20	V	32	INTEREST	229,131	SFP ASSOCIATES	100.00%		(229,131)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 229,131			$ 141,329	$ * (87,802)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	$ 1,621	S & E MEDICAL SUPPLY	100.00%	$ 1,459	$ (162)	15
16	V	10	MEDICAL SUPPLIES	631	S & E MEDICAL SUPPLY	100.00%	505	(126)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,251			$ 1,963	$ * (288)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	President	Administrative	50.00%	SEE ATTACHED	7	11.67%	SW Mgmt	$ 75,021	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 75,021		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.W. MANAGEMENT
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	Available Bed Days	488,314	8	$ 15,521	$	33,215	$ 1,056	1
2	6	REPAIRS AND MAINT.	Available Bed Days	488,314	8	14,771		33,215	1,005	2
3	17	CHIEF FINANCIAL OFFICER	Available Bed Days	488,314	8	145,056	145,056	33,215	9,867	3
4	19	PROFESSIONAL FEES	Available Bed Days	488,314	8	4,393		33,215	299	4
5	20	FEES, SUBSCRIPTIONS, DUES	Available Bed Days	488,314	8	572		33,215	39	5
6	21	CLERICAL AND GENERAL	Available Bed Days	488,314	8	434,445	380,978	33,215	29,551	6
7	24	EDUCATION AND SEMINARS	Available Bed Days	488,314	8	59		33,215	4	7
8	25	TRANSPORTATION	Available Bed Days	488,314	8	3,708		33,215	252	8
9	26	INSURANCE - PROPERTY	Available Bed Days	488,314	8	10,197		33,215	694	9
10	27	PAYROLL TAXES	Available Bed Days	488,314	8	85,313		33,215	5,803	10
11	30	DEPRECIATION	Available Bed Days	488,314	8	16,972		33,215	1,154	11
12	32	INTEREST EXPENSE	Available Bed Days	488,314	8	13,072		33,215	889	12
13	33	REAL ESTATE TAXES	Available Bed Days	488,314	8	34,195		33,215	2,326	13
14	35	AUTO LEASE	Available Bed Days	488,314	8	10,092		33,215	686	14
15										15
16	17	SALARY - SHELDON WOLFE	Avg, Hours Worked	60	9	643,036	643,036	7	75,021	16
17	17	SALARY - RONNIE KLEIN	Avg. Hours Worked	60	7	60,000	60,000			17
18	27	EMP. BEN.-SHELDON WOLFE	Avg. Hours Worked	60	9	25,346		7	2,957	18
19	27	EMP. BEN.-RONNIE KLEIN	Avg. Hours Worked	60	7	8,354				19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,525,102	$ 1,229,070		$ 131,603	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SFO ASSOCIATES
Street Address: 7434 N. SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL. 60077
Phone Number: (847) 982-2300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	$ 22,832	$	1,700,000	$ 5,971	1
2	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	517,545		1,700,000	135,358	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 540,377	$		$ 141,329	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S & E MEDICAL SUPPLY
Street Address: 3100 COMMERCIAL AVENUE
City / State / Zip Code: NORTHBROOK, ILLINOIS 60062
Phone Number: (847) 982-9300
Fax Number: (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SUPPLEMENTS	Direct Allocation						1,459	1
2	10	MEDICAL SUPPLIES	Direct Allocation						505	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 1,963	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	NOTE PAYABLE - AUTO		X				$	$ 20,362			$	1
2	DUE/FROM SHABB LLC	X						1,229,231			82,145	2
3												3
4												4
5												5
	Working Capital											
6	ST LOAN EXCHANGE		X					411,406				6
7	DUE TO/FROM SFO ASSOC	X						2,047,055				7
8												8
9	TOTAL Facility Related						$	$ 3,708,053			$ 82,145	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										87,080	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 87,080	14
15	TOTALS (line 9+line14)						$	$ 3,708,053			$ 169,225	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INT. INCOME - SHABBONA						$	$			$ (1,113)	1
2	INTEREST EXP. BLDG LLC	X									229,407	2
3	INTEREST INC. BLDG LLC	X									(48,029)	3
4	GAIN IN PARTNERSHIP	X									(301)	4
5	INTEREST EXP. SW MGMT	X									889	5
6	INTEREST EXP. SFO ASSOC.	X									135,358	6
7	INTEREST INC. SFO ASSOC.	X									(229,131)	7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ 87,080	21

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	40,848	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	44,586	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,738	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	44,373	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	48,111	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	34,597	8
1998	34,503	9
1999	38,223	10
2000	38,904	11
2001	42,260	12

R.E. ACCRUAL 2002 = $42,260 X 1.05 = $44,373 Ln 4 above

ALLOC. SW. MGMGT = $2,326 Incl. Ln 2 above

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHABBONA HEALTHCARE CENTER COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0032169

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-15-327-010	Long-Term Care Property	$ 42,260.00	$ 42,260.00
2.	10-28-412-049-0000	Alloc S.W. Mgmt	$ 35,720.85	$ 2,331.94
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,980.85	$ 44,591.94

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHABBONA HEALTHCARE CENTER COUNTY DEKALB

FACILITY IDPH LICENSE NUMBER 0032169

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,200 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 87616 - SHABBONA LLC
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 2,921
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SHABBONA LLC			$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	2,650		20	177	177	2,463	9
10	Various			1990	65,810		20	3,290	3,290	41,420	10
11	Various			1991	20,535		20	1,027	1,027	13,271	11
12	Various			1992	5,466		20	273	273	3,917	12
13	Various			1993	13,848		20	685	685	6,429	13
14	Various			1994	39,334		20	1,967	1,967	17,276	14
15	Various			1995	13,479		20	674	674	6,084	15
16	Various			1996	11,533		20	577	577	4,620	16
17	Various			1997	18,996		20	950	950	5,513	17
18	Various			1998	141,664		20	7,084	7,084	34,258	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,679,500	68,740		68,998	258	582,076	68
69	Financial Statement Depreciation			9,512			(9,512)		69
70	TOTAL (lines 4 thru 69)		$ 3,012,815	$ 78,252		$ 85,702	$ 7,450	$ 717,327	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,012,815	$ 78,252		$ 85,702	$ 7,450	$ 717,327	1
2	CONCRETE	1999	2,415		20	121	121	444	2
3	A/R HANDLER	2000	1,150		20	115	115	307	3
4	A/R HANDLER	2000	1,870		20	187	187	483	4
5	A/R HANDLER	2000	1,900		20	190	190	475	5
6	DRIVEWAY	2001	3,040		20	152	152	190	6
7	AIR HANDLER	2001	1,350		20	135	135	236	7
8	SECURITY SYSTEM	2001	1,507		20	151	151	201	8
9	TELEPHONE SYSTEM	2001	1,928		20	193	193	273	9
10	NURSE CALL SYSTEM	2001	2,745		20	275	275	413	10
11	HEATING /COOLING SYSTEM	2002	1,078		20	54	54	54	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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19									19
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,031,798	$ 78,252		$ 87,275	$ 9,023	$ 720,403	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	91		1994		$ 2,643,587	$ 67,784	39	$ 67,784	$	$ 573,418	4
5											5
6			1995		29,379	753		839	86	6,425	6
7											7
8											8
	Improvement Type**										
9	ALLOC SW MANAGEMENT			1995	3,141	105	20	188	83	1,393	9
10	ALLOC SW MANAGEMENT			1996	549	14	20	27	13	180	10
11	ALLOC SW MANAGEMENT			1997	790	31	20	57	26	298	11
12	ALLOC SW MANAGEMENT			1998	544	14	20	27	(13)	129	12
13	ALLOC SW MANAGEMENT			1999	1,510	39	20	76	37	233	13
14											14
15											15
16											16
17											17
18											18
19											19
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21											21
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,679,500	$ 68,740		$ 68,998	$ 232	$ 582,076	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 108,641	$ 87	$ 10,467	$ 10,380	10	$ 72,464	71
72	Current Year Purchases	36,398	16,251	4,564	(11,687)	10	4,564	72
73	Fully Depreciated Assets	244,194				10	244,194	73
74								74
75	TOTALS	$ 389,233	$ 16,338	$ 15,031	$ (1,307)		$ 321,222	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		98 OLDSMOBILE	1995	$ 21,506	$ 1,775	$	$ (1,775)	5	$ 20,982	76
77		2001 GRAND JEEP	2001	33,668	4,900	4,900		5	7,960	77
78										78
79										79
80	TOTALS			$ 55,174	$ 6,675	$ 4,900	$ (1,775)		$ 28,942	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,526,205	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 101,265	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,206	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,941	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,070,567	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2002 CHRYSLER	$ 124.58	$ 653	17
18	ALLOC. SW MGMT			686	18
19					19
20					20
21	TOTAL		$ 124.58	$ 1,339	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	12

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	3

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,812	$	$ 1,812
2	Books and Supplies		98		98
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,910	$	$ 1,910
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,910			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 40,764	$		$ 40,764	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			843			843	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			65,050			65,050	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				21,541		21,541	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						2,790		2,790	13
14	TOTAL			$		$ 106,657	$ 24,331		$ 130,988	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 373,218	$ 373,218	1
2	Cash-Patient Deposits	265	265	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	392,119	392,119	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments		28,113	5
6	Prepaid Insurance	13,523	13,523	6
7	Other Prepaid Expenses	1,130	1,130	7
8	Accounts Receivable (owners or related parties)	107,279	107,279	8
9	Other(specify): See Supplemental Schedule	11,544	11,544	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 899,078	$ 927,191	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		2,643,587	14
15	Leasehold Improvements, at Historical Cost	317,103	317,103	15
16	Equipment, at Historical Cost	261,093	470,393	16
17	Accumulated Depreciation (book methods)	(273,168)	(1,055,886)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		87,616	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(24,886)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 305,028	$ 2,487,927	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,204,106	$ 3,415,118	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 85,338	$ 85,338	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	1,099	1,099	28
29	Short-Term Notes Payable	1,255,432	1,640,637	29
30	Accrued Salaries Payable	49,385	49,385	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,362	7,362	31
32	Accrued Real Estate Taxes(Sch.IX-B)	44,373	44,373	32
33	Accrued Interest Payable	31,587	31,587	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,474,576	$ 1,859,781	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	20,362	2,067,416	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 20,362	$ 2,067,416	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,494,938	$ 3,927,197	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (290,832)	$ (512,079)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,204,106	$ 3,415,118	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (73,457)	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (73,457)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(217,375)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (217,375)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (290,832)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,176,935	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,176,935	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	46,864	6
7	Oxygen	9,302	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 56,166	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,979	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	28,110	21
22	Laundry	6,083	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 38,172	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,113	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,113	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	1,121	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,121	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,273,507	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	779,230	31
32	Health Care	1,279,758	32
33	General Administration	787,338	33
	B. Capital Expense		
34	Ownership	459,845	34
	C. Ancillary Expense		
35	Special Cost Centers	134,888	35
36	Provider Participation Fee	49,823	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,490,882	40
41	**Income before Income Taxes (line 30 minus line 40)****	(217,375)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (217,375)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,552	1,642	$ 39,472	$ 24.04	1
2	Assistant Director of Nursing	171	195	3,186	16.34	2
3	Registered Nurses	5,250	6,812	153,713	22.57	3
4	Licensed Practical Nurses	8,259	9,258	195,129	21.08	4
5	Nurse Aides & Orderlies	52,432	52,113	635,789	12.20	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,580	6,027	76,274	12.66	10
11	Social Service Workers	5,199	5,519	84,251	15.27	11
12	Dietician					12
13	Food Service Supervisor	2,426	2,570	37,062	14.42	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,552	14,371	108,395	7.54	15
16	Dishwashers					16
17	Maintenance Workers	4,199	4,325	62,284	14.40	17
18	Housekeepers	20,472	21,780	181,573	8.34	18
19	Laundry	8,848	9,185	71,427	7.78	19
20	Administrator	2,000	2,080	58,089	27.93	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,199	5,519	138,869	25.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	135,139	141,396	$ 1,845,513 *	$ 13.05	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	103	$ 6,720	01-03	35
36	Medical Director	Monthly	4,761	09-03	36
37	Medical Records Consultant	53	263	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	112	2,790	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	3	150	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	335	8,383	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	606	$ 23,067		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	219	$ 5,490	10-03	50
51	Licensed Practical Nurses	551	10,997	10-03	51
52	Nurse Aides	3,208	38,497	10-03	52
53	TOTAL (lines 50 - 52)	3,978	$ 54,984		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DONNA REED	Administrator	0%	$ 32,261
1.1.01- 5.31.02			
EILEEN GATES	Administrator	0%	25,828
6.1.02 - 12.31.02			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,089

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - SW MGMT	$ 60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 60,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
PERSONNEL PLANNERS	UNEMPLOYMENT CLST	$ 316
SEE ATTACHED	LEGAL	10,966
FR&R	ACCOUNTING	18,536
SW MGMT	HOME OFFICE	61,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 91,017

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,253
Unemployment Compensation Insurance	22,567
FICA Taxes	140,371
Employee Health Insurance	77,520
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
MISC EMPL BENEFITS/DISABILITY	3,700
HOLIDAY EXPENSE	409
TOTAL (agree to Schedule V, line 22, col.8)	$ 288,820

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	22,648
Health Care Worker Background Check	
(Indicate # of checks performed 45)	540
ILL.COUNCIL LTC	3,243
DUES & SUBSCRIPTIONS	189
LICENSES	1,000
PERMITS	225
ALLOC. SW MGMT	39
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 27,884

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,240
ALLOC. SW MGMT	4
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,244

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SHABBONA HEALTHCARE CENTER # 0032169 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Ill.Council LTC - $ 4,668**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **49,823**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **NO**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees